CERTIFICATION OF DISABILITY

(PLEASE PRINT LEGIBLY OR TYPE)

All information must be completed by a professional.

Applicant Name

(Last) ______________________ (First)______________________(MI) ____

Please check one.

I am a(n):

☐ Audiologist

☐ Physician

☐ Speech-Language Pathologist

☐ Physician's Assistant

☐ Vocational Rehabilitation Counselor

☐ Registered Nurse Practitioner

☐ Optometrist

☐ Ophthalmologist

☐ Service Professional (public or private agency that serves deaf, hard of hearing and deafblind, Center for Independent Living employee, credentialed Assistive Technology Professional)

Please check the disability(ies) being certified:

☐ cognitive*

☐ deaf

☐ deafblind

☐ hard of hearing

☐ low vision

☐ blind

☐ physical*

☐ speech

*If you marked cognitive or physical disability, please explain why the applicant needs a specialized phone. ______________________

Certifying Professional

Full Name______________________Title______________________

Agency ______________________

PA Professional License Number, if applicable ______________________

Phone______________________Fax ______________________

Email______________________

I certify that the applicant named above has the disability indicated, and that they require this technology to independently access telecommunication services.

Signature of Certifier______________________Date ______________________